

# **IOWA MEDICAID IOWA PLAN FOR BEHAVIORAL HEALTH**

## **Proposal for a Section 1915(b) Capitated Waiver Program Waiver Renewal Submittal**

**May 2003**

### **Section G. APPEALS, GRIEVANCES, AND FAIR HEARINGS**

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MCOs/PIHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

Internal grievance procedures are optional for PAHPs.

States, MCOs, PIHPs, and PAHPs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- other requirements for fair hearings found in 42 CFR 431 Subpart E.

## I. Definitions (MCO/PIHP):

### Upcoming Waiver Period --

- a. ☒ [Required] The definition of action in the case of an MCO/PIHP means:
- ☒ Denial or limited authorization of a requested service, including the type or level of service;
  - ☒ The reduction, suspension, or termination of a previously authorized service;
  - ☒ The denial, in whole or in part, of a payment for a service;
  - ☒ The failure to provide services in a timely manner
  - ☒ The failure to act within timeframes required by 42 CFR 438.408(b); or
  - ☒ For a resident of a rural area with only on MCO, the denial of the enrollee's request to exercise his or her right to obtain services outside the network.
- b. ☒ Appeal means a request for a review of an action.
- c. ☒ Grievance means an expression of dissatisfaction about any matter other than an action.
- d. Please describe any special processes that the State has for persons with special needs.

## II. Grievance Systems Requirements (MCO/PIHP):

### Previous Waiver Period

- a. [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to appeals, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint, item G.II 1999 Upcoming Waiver Renewal Preprint]. Also, please provide summary information on the types of appeals, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Strategy.

### **RESPONSE:**

**1. During the previous waiver period, the PIHP maintained three protocols to resolve dissatisfaction with the Iowa Plan. They are**

**A. The Care Review process is designed to resolve clinical disagreements regarding authorized levels of care. The PIHP**

maintain two steps to the Care Review process: Level I, Level II. Since the PIHP does not require authorization for most outpatient services, Care Reviews typically involve higher levels of care, with 70% involving requests for inpatient services.

- **Level I:** 35% of clinical non-authorization resulted in a Level I Care Review (Level I is the first step) during 2002. This compares to 35% during the previous year.
- **Expedited Level I Care Review:** If an enrollee is receiving services when the PIHP non-authorizes the service, the provider or enrollee can request an expedited Level I care review. The PIHP provides a telephonic response within 24 hours. 13% of the Level I Care Reviews were expedited.
- **Level II:** 43% of Level I Care Reviews resulted in a Level II Care Review during 2002. 98% involved mental health services and 2% for substance abuse treatment.
- The PIHP mailed notices of Care Review decisions to providers and enrollees within the required 14-day timeframe for 100% of Level II reviews and 98.6% of Level I reviews. State monitored the PIHP's failure to meet the timeframe requirements during the first part of calendar year 2002 as a result of administrative changes. State monitored the PIHPs corrective action and the performance improved by the end of 2002.

B. The **Grievance** process, as defined during the previous waiver period, is designed to resolve administrative issues. Typically, a grievance involves a non-authorization decision that was made based on administrative rather than clinical issues, such as the provider failed to pre-authorize a service. The grievance review takes into consideration the circumstances pertaining to why the provider failed to request authorization.

- 264 grievances were filed during 2002: 81 for inpatient care.

C. The **Complaint** process, as defined during the previous waiver period, is for any issue identified as a complaint by a stakeholder regarding the Iowa Plan, the Iowa Plan PIHP, or a provider.

- 52 complaints were reported during 2002: 35 were resolved the same day and all were resolved within 5 days.

- **Source of Complaints:** providers = 23; enrollees = 17; other = 12.
- **Type of complaint:** about clinical care received from the provider= 20; about service from the PIHP = 16; about access to care = 5; about non-authorizations = 11

**D. The PIHP's Annual Quality Assurance Report includes an analysis of the subjects and outcomes of care reviews, complaints, and grievances, including timeframes required to reach resolution and action taken in response to trends. See attachment to G.II, titled 5.15.11**

**2. In addition to Care Reviews, Grievances and Complaints, the PIHP monitors Provider Incidents which may come to the PIHP's attention during the care review process or from various sources. During 2002, the PIHP processed 80 Provider Incidents, down from 135 the previous year. The PIHP investigation of Provider incidents may include phone calls, written requests, review of client medical records.**

**Example:** During a care review discussion between the PIHP's care manager and the provider, the PIHP became aware substance abuse use by an enrollee out on pass from a 24 hour level of care, but noted that the provider had not evaluated the client upon return to the facility. The PIHP's concerns were related to the provider with the requirement that the provider document corrective action. The provider complied and implemented appropriate policies. State monitored the process on an on-going basis through weekly up-dates at weekly management and oversight meetings.

**See attachment to section G.II, titled Provider Incidents.**

- 3. In addition, the PIHP provides monthly reports of the following: (See attachment to G.II for a sample of these monthly reports.)**
- **Summary of non-clinical complaints:** # received, pending, resolved, broken out by source of complaint, mental health, substance abuse. (Monthly Report - IACS01)
  - **Timing of non-clinical complaint resolution:** broken out by source of complaint, mental health, substance abuse. (Monthly Report - IACS02)
  - **Summary of non-clinical grievances:** # received, pending, resolved, broken out by source of complaint, mental health, substance abuse. (Monthly Report - IACS03)
  - **Timing of non-clinical grievance resolution:** broken out by

**source of complaint, mental health, substance abuse.  
(Monthly Report - IACS04)**

**b.** Please mark any of the following that apply:

1.   X   A hotline was maintained which handles any type of inquiry, complaint, or problem.

**RESPONSE:**

**Medicaid beneficiaries may access the State's Medicaid hot line or may access the PIHP's 24 hour recipient hot line.**

2.   X   Following this section is a list or chart of the number and types of complaints and/or grievances handled during the waiver period.

3.   X   There is consumer involvement in the grievance process. Please describe.

**RESPONSE:**

**State requires the PIHP to provide Medicaid beneficiaries the opportunity to participate in the Care Review/Grievance/Complaint process.**

- **A review of QI quarterly reports documents that enrollees filed 4 grievances during the past five quarters.**
- **25 of the 65 Complaints recorded during the first 18 months were from enrollees. See attachment G.II.c.2, Complaints.**

**The PIHP sends notification of all complaint, grievance, and care review decisions to the Medicaid beneficiary, regardless of whether or not they initiated or participated in the action.**

**Medicaid beneficiaries may access the State's Appeal (fair hearing) process at any time an adverse action has occurred and are notified of all decisions, regardless of whether they participated in the Appeal hearing.**

**Upcoming Waiver Period --** Please check requirements in effect for MCO/PIHP grievance processes.

**a. Required Appeals, Grievances, and Fair Hearings Elements for MCOs/PIHPs:**

1.  X  MCO/PIHPs have a system in place for enrollees that include a grievance process, an appeals process, and access to the State's fair hearing process.

**RESPONSE:**

**The PIHP enrollee handbook advises enrollees how to make a complaint or appeal (Fair Hearing) to either the PIHP or the State. State requires the PIHP to mail handbooks to all new enrollees within 10 days after enrollment (actual time averages 5-6 days). Additionally, the PIHP's client newsletter annually advises beneficiaries of how to initiate the complaint/grievance process. See attachment to G.II.a.6**

**Enrollees are informed about their State fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.**

**The MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.**

2.  X  An MCO/PIHP enrollee can request a State fair hearing under the State's Fair Hearing process. The State permits  
(A)  X  direct access without first exhausting the MCO/PIHP grievance process  
(B)   exhaustion of MCO/PIHP grievance process before a State fair hearing can be accessed

**RESPONSE:**

**Medicaid beneficiaries may access the State's Fair Hearing process at any time the beneficiary has experienced an adverse action in response to a request for covered benefits.**

3.  X  Enrollees are informed about their State fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.
4.   The state specifies a time frame that is no less than 20 days and does not exceed 90 days from the date **on the MCO's or PIHP's notice of action** for the enrollee to request an appeal or fair hearing. Specify the time frame \_\_\_\_\_

**RESPONSE:**

**The State requires 95% of reviews (other than expedited reviews) be completed within 14 days and 100% completed within 90 days.**

5. X [Optional] The State has time frames for resolution of grievances. Specify the time frame set by the State \_\_\_\_\_

**RESPONSE:**

**The State requires 95% of reviews (other than expedited reviews) be completed within 14 days and 100% completed within 90 days.**

6. X The MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.

7. X The MCO/PIHP acknowledges receipt of each appeal and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PIHPs to acknowledge complaints and grievances, please specify:

**RESPONSE:**

**Written acknowledgement of a request for review is required within 3 working days of receipt of the request.**

8. X The MCO/PIHP gives enrollees assistance completing forms or other assistance necessary in filing appeals or grievances (or as appeals and grievances are being resolved).

**RESPONSE:**

**Medicaid beneficiaries may initiate the process with either a written or verbal request.**

9. X The MCO/PIHP ensures individuals who make decisions were not involved in previous levels of decision making.

**RESPONSE:**

**The Iowa Plan contract, section 45.0 specifies requirements for the PIHP internal process for review of clinical decisions and non-clinical decisions.**

**The Level I review of clinical decisions must be conducted by a physician or other qualified health care professional who was**

**not involved in the decision not to authorize the requested care.**

**The second level review of clinical and non-clinical decisions must be conducted by a person (physician for clinical decisions) other than the person who was involved in the first level review.**

10. X The MCO/PIHP ensures individuals who make decisions are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease.

**The PIHP uses physicians reviewer who are specialists in the areas of child/adolescent and adult mental health and substance abuse treatment.**

11. \_\_\_ The MCO/PIHP ensures the special requirements for appeal, i.e. on oral inquiries, reasonable opportunity to present evidence; ability to examine case file, and inclusion of parties to appeal in 42 CFR 438.406(b) are met.

12. \_\_\_ Timeframes for resolution:

(a) \_\_\_ Grievances are resolved within \_\_\_ days (may not exceed 90 days from date of receipt by MCO/PIHP)

(b) \_\_\_ Standard appeals are resolved in \_\_\_ days (may not exceed 45 days from date of receipt by MCO/PIHP).

(c) \_\_\_ Expedited appeals are resolved in \_\_\_ days (may be no more than 3 working days from date of receipt by MCO/PIHP, unless extended).

**RESPONSE:**

**The State requires 95% of reviews (other than expedited reviews) be completed within 14 days and 100% completed within 90 days.**

**Providers and enrollees have the right to request a review of non-authorization for admission to or continuation of 24-hour services and have a decision within 24 hours of the time the request for review was made.**

**(Note: Most Medicaid covered outpatient services do not require prior authorization.)**

**Analysis of subjects and outcomes of care reviews and complaints/grievances, including timeframes, are included in the PIHP's QI quarterly reports. The QI reports are available to providers and enrollees upon request and are routinely provided and verbally summarized at consumer, provider and other stakeholder roundtables.**

13. ☐ Timeframes for resolution may be extended for up to 14 calendar days if it meets the requirements of 42 CFR 438.408(c).
14. ☒ The MCO/PIHP notifies the enrollee in writing of the appeals decision and, if not favorable to the enrollee, the right to request a State fair hearing, including rights to continuation of benefits. The format and content of the notice meet the requirements of 42 CFR 438.408(d)-(e).

**Response**

**MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.**

15. ☒ The MCO/PIHP complies with the requirements on availability of and parties to State fair hearings in 42 CFR 438.408(f).
16. ☒ The MCO/PIHP maintains an expedited review process for appeals when it is determined that the standard resolution timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. This includes the prohibitions on punitive actions, and action following denial of request for expedited resolution in 42 CFR 438.410.

**RESPONSE:**

**Providers and enrollees have the right to request a review of non-authorization for admission to or continuation of 24-hour services and have a decision within 24 hours of the time the request for review was made.**

**(Note: Most Medicaid covered outpatient services do not require prior authorization.)**

17. ☐ The MCO/PIHP informs the enrollee of any applicable mechanism for resolving the issue external to the MCO's/PIHP's own processes (e.g. independent state review mechanism).

18. X MCOs/PIHPs maintain a log of all appeals and grievances and their resolution.

**Response**

The PIHP's Annual Quality Assurance Report summarizes complaints and grievances. The summary pages are included as an attachment to G.II.c.2.Change

In addition, the PIHP provides monthly reports of the following:

- Summary of non-clinical complaints: # received, pending, resolved, broken out by source of complaint, mental health, substance abuse. (Monthly Report - IACS01)
- Timing of non-clinical complaint resolution: broken out by source of complaint, mental health, substance abuse. (Monthly Report - IACS02)
- Summary of non-clinical grievances: # received, pending, resolved, broken out by source of complaint, mental health, substance abuse. (Monthly Report - IACS03)
- Timing of non-clinical grievance resolution: broken out by source of complaint, mental health, substance abuse. (Monthly Report - IACS04)

19. \_\_\_ The State reviews information on each MCO/PIHP's appeals as part of the State quality strategy.

20. X The State and/or MCO/PIHP have ombudsman programs to assist enrollees in the appeals, grievance, and fair hearing process.

**RESPONSE:**

The State operates an ombudsman program which may be accessed by Medicaid beneficiaries in issues pertaining to complaints, grievances and the fair hearing process.

21. \_\_\_ Other (please specify):

**RESPONSE:**

The Iowa Plan contract, section 45.2 requires that in the event services are terminated before the authorized period is exhausted and an appeal is filed, the PIHP is required to continue services through the authorized period or until the appeal hearing final decision, which occurs first.

### **III. PAHP Requirements**

1. \_\_ [Optional] PAHPs have an internal grievance system. Please describe.

2. \_\_ [Required] PAHP enrollees have access to the State fair hearing process.